ennsylvania Insurance Depart omparison of Essential Health		k Plans for Selection of	Benchmark Plan for Use in	2017	Key: ✓ = covered text in boxes descri		L = limited coverage	= not addressed in t	federal summary of current EHB-bas	
	Current EHB Base-	Largest Small Group Plans				oyee Health Plans	Federal Employees HBP Benchmark Plans			Largest Largest FEDVIP Largest FEDVIP CHIP Dental Vision
Benefits*	Benchmark Plan [Aetna HMO (POS)] <sup>1</sup>	1 - Keystone Health Plan East (IBC HMO) <sup>2</sup>	2 - Highmark (PPO) <sup>3</sup>	3 - Geisinger Quality Options (PPO) <sup>4</sup>	4 - PPO <sup>5</sup>	5 - HMO⁵	6 - BCBS Standard Option PPO <sup>6</sup>	7 - BCBS Basic Option PPO <sup>6</sup>	8 - GEHA Standard Option PPO <sup>7</sup>	UPMC for Kids 8
1 Ambulatory Patient Services										Option
Primary Care to Treat An Illness or Injury	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Specialist Visit	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Other Practitioner Office Visit (Nurse, Physician Assistant)	✓	✓	✓ certified registered nurse practitioners	Not specified	✓	<b>✓</b>	<b>✓</b>	✓	✓	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	✓	✓	Not specified	<b>✓</b>	✓	✓	✓	✓	✓	
Outpatient Surgery Physician/Surgical Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Home Health Care Services	√   60 visits per year	✓ 60 visits per year	✓ 90 visits per year	✓	✓	✓ 60 days per 90-day period	√ 50 visits per year, up to 2 hours per day	√ limit 25 visits per year, up to 2 hours per day	✓ limit 50 visits per year, up to 2 hours per day	
Private Duty Nursing	$\otimes$	✓ 120 day limit per benefit period. Precertification required.	✓ 240 hours per year	limited to medically necessary acute hospital private duty registered nurse services.		$\otimes$		$\otimes$		
Chemotherapy		✓	✓	✓	✓	✓	✓	✓	✓	
Radiation		✓	✓	✓	✓	✓	✓	✓	✓	
Dialysis		✓	✓	✓	✓	✓	✓	✓	✓	
Allergy Injection		✓	✓	0	✓	✓	✓	✓	✓	
Routine Dental Services (Adult)***	$\otimes$	$\otimes$			$\otimes$	$\otimes$	L plan pays nominal amount for a list of services	L 2 evaluations and cleanings per year covered	L plan pays 50% of plan allowance for 2 exams and cleanings per year and \$75 in X-rays per year. Plan pays nominal amount for fillings and simple extractions.	
Accidental Dental		✓	L only for accidental injury to the jaw or structures contiguous to the jaw except teeth	✓	✓	✓	✓	<b>√</b>	✓	
Routine Eye Exam (Adult)***	✓ 1 exam every 2 years	✓ 1 exam per year		✓ 1 exam per year			only as a result of accidental injury or surgery	only as a result of accidental injury or surgery	Outpatient Vision therapy visits by an ophthalmologist or optometrist included	
Routine Foot Care						only podiatric care for treatment of disease or injury. Routine diabetic foot care limit 4 visits per year	only due to a metabolic or peripheral	only due to a metabolic or peripheral vascular disease, such as diabetes	only due to a metabolic or peripheral vascular disease, such as diabetes	
Chiropractic Care / Spinal Manipulations	✓ 20 visits per year	✓ 20 visits per year	✓ 20 visits per year	✓ 20 visits per year	√ treatment plan required after six visits per year	does not cover visits for maintenance of a condition. Combined limit of 60 visits per year on spinal manipulation/PT/OT/ST/cardiac rehab/pulmonary rehab	ilmit 12 visits per year	√ limit 12 visits per year	✓ limits: \$20 per visit; 12 visits per year; \$25 for x-rays per year	3

ennsylvania Insurance Departr omparison of Essential Health		k Plans for Selection of	Benchmark Plan for Use in 2	2017	Key: ✓ = covered text in boxes descri		L = limited coverage	= not addressed in f	ederal summary of current EHB-bas	e benchmark plan
	Current EHB Base-		Largest Small Group Plans		PA State Emplo	oyee Health Plans	Federal Employees HBP Benchmark Plans			Largest Largest FEDVIP Larg
Benefits*	Benchmark Plan [Aetna HMO (POS)] <sup>1</sup>	1 - Keystone Health Plan East (IBC HMO) <sup>2</sup>	2 - Highmark (PPO) <sup>3</sup>	3 - Geisinger Quality Options (PPO) <sup>4</sup>	4 - PPO <sup>5</sup>	5 - HMO <sup>5</sup>	6 - BCBS Standard Option PPO <sup>6</sup>	7 - BCBS Basic Option PPO <sup>6</sup>	8 - GEHA Standard Option PPO <sup>7</sup>	UPMC for MetLife Federal Dental Plan – High High
Acupuncture	0	0	Not specified	0		0	✓ 24 visits per year	√ 10 visits per year	✓ 20 procedures per year	
Treatment for Temporomandibular Joint Disorders (TMJ)				surgery to correct dislocation or degeneration; consultations to determine need for surgery; radiologic determination of pathology. General anesthesia not covered.		0	reduction of dislocations and excision of temporomandibular joints	reduction of dislocations and excision of temporomandibular joints	√ surgery only	
Cosmetic/Reconstructive Surgery (all plans cover reconstructive surgery associated with mastectomy)	0	only to correct results of congential defect, recent trauma, disease, or previous therapeutic process	only to correct results of congentical defect, accident, or functional impairment resulting from a covered disease or injury	only to correct results of congentital defect, accident, covered sickness, or incidental to surgery	Not specified	Not specified	only to correct a functional or congenital defect or defect from sickness, accidental injury, or surgery	only to correct a functional or congenital defect or defect from sickness, accidental injury, or surgery.	only to correct a functional defect; a congenital defect (if a significant deviation from the norm; only for <18 years old unless there is a funcitonal defect); or a defect from sickness or accidental injury if their ia a major effect on the member's appearance.	
Infertility Treatment		L Artificial innsemination is covered. Excludes assisted fertilization techniques	L excludes artificial insemination procedures and assisted reproduction technology	L only diagnosis of infertility is covered	0	0	L excludes assisted reproduction technology and artificial insemination procedures	L excludes assisted reproduction technology and artificial insemination procedures	L excludes assisted reproduction technology and artificial insemination procedures	
Gender Reassignment Surgery		0		0	0	0	⊗	<u> </u>		
Non-Emergency Care When Traveling Outside	<i>⊗</i>	<b>√</b>	<b>√</b>				✓	<b>√</b>	✓	
the U.S. Emergency Services	<u> </u>	,	·	9	ů,	G	·	,	·	
Emergency Room Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Emergency Transportation/Ambulance	✓	✓	✓	<b>✓</b>	✓	✓	✓	✓	✓	
Urgent Care Centers or Facilities	√ no coverage for non-urgent care	✓	<b>√</b>	<b>✓</b>	<b>✓</b>	<b>√</b>	Covered for accidental ingury and medical emergency; not specified whether covered for other conditions	Covered for accidental ingury and medical emergency; not specified whether covered for other conditions	Covered for accidental ingury and medical emergency; not specified whether covered for other conditions	
Hospitalization										
Inpatient Hospital Services (e.g., Hospital Stay)	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Inpatient Physician and Surgical Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Skilled Nursing Facility	✓ 120 days per year	√ 120 days per year	✓ 120 days per year	✓ 120 days per year	✓ 240 days per year	√ 180 days per year	L coverage for days 21 - 30 only when Medicare Part A is primary		✓ 14 days following acute care, up to \$700 per day	
Long-Term/Custodial Nursing Home Care***	$\otimes$	$\Diamond$	$\otimes$	$\Diamond$	$\otimes$	$\Diamond$	$\otimes$	$\Diamond$	$\otimes$	
Hospice	✓	✓ respite care covered for 7 days per 6 months	√ no respite care	✓ respite care covered	Iifetime max of \$7,500; respite care covered at max 10 days of facility care or 240 hours of in-home care, and counts towards the overal hospice lifetime max of \$7,500	days of facility care or 240 hours of in-home care, and	care with periodic visits.  -Continuous home hospice care (requiring minimum 8 hours of care per 24 hour period) limited to max 7 continuous days of coverage, with each continuous care period separated by at least 21 days of traditional home hospice care.  -Inpatient hospice care limited to 30 consecutive days per stay, and each stay must be seperated by at least 21	separated by at least 21 days of traditional home hospice careInpatient hospice care limited to 30 consecutive days per stay, and each	\$15,000 per period. A new period begins after three months from prior discharge from hospice care.	

Pennsylvania Insurance Depart Comparison of Essential Health		Plans for Selection of I	Benchmark Plan for Use in 2	2017	Key: ✓ = covered			= not addressed in federal summary of current EHB-base benchmark plan				
	Current EHB Base-		Largest Small Group Plans			yee Health Plans		Largest CHIP	Largest FEDVIP Larg	rgest FEDVIF Vision		
Benefits*	Benchmark Plan [Aetna HMO (POS)] <sup>1</sup>	1 - Keystone Health Plan East (IBC HMO) <sup>2</sup>	2 - Highmark (PPO) <sup>3</sup>	3 - Geisinger Quality Options (PPO) <sup>4</sup>	4 - PPO <sup>5</sup>	5 - HMO <sup>5</sup>	6 - BCBS Standard Option PPO <sup>6</sup>	7 - BCBS Basic Option PPO <sup>6</sup>	8 - GEHA Standard Option PPO <sup>7</sup>	UPMC for Kids <sup>8</sup>	MetLife Federal FEP	P BlueVision ligh Option <sup>10</sup>
Transplant		✓	✓	for specified list of organs. No coverage for a Member who donates to a non-Member. Travel, lodging, and meals incurred in conjunction with transplant reimbursed at \$200/day to a max of \$5000 per transplant	✓	<b>√</b>	✓ for specified list of organs/diagnoses. Artificial organs not covered.	<ul><li>✓</li><li>for specified list of organs/diagnoses.</li><li>Artificial organs not covered.</li></ul>	for specified list of organs/diagnoses. Covers up to \$10,000 per covered transplant for transportation and living expenses for recipient and one other individual (two others in the case of a minor).  Artificial organs not covered.			
Blood		✓	✓	0	0	0	✓	✓	✓	1		
Bariatric Surgery	0	⊗		⊗			limitations include: requiring morbid obesity diagnosis for 2+ Years, participation in medical weight loss programs and nutritional counseling for 3+ months, psychological clearance, smoking/substance abuse clearance, evidence that prior weight loss attempts have been ineffective; BMI >=40, or BMI >=35 w/1+ comorbidity		Ilimitations include: requires documentation of failure to lower the BMI within the last 12 months through a medically superviced program of diet and exercise of at least 6 months' duration, must be over age 18:  BMI >=40, or BMI >=35 w/1+ co-morbidity			
4 Maternity & Newborn Care												
Prenatal and Postnatal Care	✓	✓	✓	Not specified. \$100 per female member covered for childbirth preparedness class	✓	<b>✓</b>	✓	✓	✓			
Delivery and All Inpatient Services for Maternity Care	<b>√</b>	<b>✓</b>	✓	<b>✓</b>	<b>✓</b>	<b>√</b>	✓	<b>✓</b>	<b>√</b>			
Mental Health & Substance Use Disorder												
5 Services  Mental/Behavioral Health Inpatient Services	Limit 30 visits per year for serious mental illness. Limit 30 visits per year for non-serious illness.	<b>√</b>	✓	<b>✓</b>		Yes; limit 1 physician visit per covered day unless covered by per diem		Yes; excludes testing and treatment for learning disabilities and mental retardation and applied behavior analysis (ABA); excludes residential treatment centers	Yes; excludes testing and treatment for learning disabilities and mental retardation and applied behavior analysis (ABA)			
Mental/Behavioral Health Outpatient Services	Limit 60 visits per year for serious mental illness. Limit 20 visits per year for non-serious illness.	✓	✓	L not specified whether outpatient services are covered for Non-Serious Mental Illness	✓	<b>√</b>	Yes; excludes testing and treatment for learning disabilities and mental retardation and applied behavior analysis (ABA); excludes residential treatment centers	Yes; excludes testing and treatment for learning disabilities and mental retardation and applied behavior analysis (ABA); excludes residential treatment centers	<b>√</b>			
Substance Abuse Disorder Inpatient Services	Rehab - Limit 30 days per year; limit 90 days per lifetime	✓	✓	✓	✓	✓	✓	✓	✓			
Substance Abuse Disorder Outpatient Services	Rehab - Limit 60 visits per year; limit 120 visits per lifetime.	✓	✓	✓	✓	✓	✓	✓	✓			
Substance Abuse Disorder - Detoxification	Inpatient: Limit 4 admissions per lifetime. Outpatient: No limits.	<b>✓</b>	✓	<b>✓</b>	<b>✓</b>	✓	Not specified	<b>✓</b>	✓			

ennsylvania Insurance De				•••	Key: ✓ = covered		L = limited coverage	= not addressed in federal summary of current EHB-base benchmark plan					
omparison of Essential He	ealth Benefits Benchmar Current EHB Base-	k Plans for Selection of B	Benchmark Plan for Use in Largest Small Group Plans	2017	text in boxes describes coverage  PA State Employee Health Plans			Largest Largest FEDVIP Largest FEDVIP					
Benefits*	Benchmark Plan	1 - Keystone Health Plan East (IBC HMO) <sup>2</sup>	2 - Highmark (PPO) <sup>3</sup>	3 - Geisinger Quality Options (PPO) <sup>4</sup>	4 - PPO <sup>5</sup>	5 - HMO <sup>5</sup>	6 - BCBS Standard Option PPO <sup>6</sup>	Federal Employees HBP Bend 7 - BCBS Basic Option PPO <sup>6</sup>	8 - GEHA Standard Option PPO <sup>7</sup>	CHIP Dental Vision  UPMC for MetLife Federal Dental Plan – High Option  Kids Plan – High Option			
Prescription Drugs													
Generics	No coverage for out-of- network. Precertification and step therapy required with 90 day Transition of Care. Includes diabetic supplies, oral fertility drugs and contraceptive drugs and devices obtainable from a pharmacy.	✓ 70% for out-of-network.	✓ No coverage for out-of-network	✓ No coverage for out-of-network	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.	✓ Benefit levels change depending on Tier Level of the Drug. No coverage for out-of-network	✓ Benefit levels change depending on Tier Level of the Drug. No coverage for out-of-network	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.				
Preferred Brand Drugs	No coverage for out-of- network. Precertification and step therapy required with 90 day Transition of Care. Includes diabetic supplies, oral fertility drugs and contraceptive drugs and devices obtainable from a pharmacy.	✓ 70% for out-of-network.	✓ No coverage for out-of-network	✓ No coverage for out-of-network	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.	✓ Benefit levels change depending on Tier Level of the Drug. No coverage for out-of-network	Benefit levels change depending on Tier Level of the Drug. No coverage for out-of-network	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.				
Non-Preferred Brand Drugs	No coverage for out-of- network. Precertification and step therapy required with 90 day Transition of Care. Includes diabetic supplies, oral fertility drugs and contraceptive drugs and devices obtainable from a pharmacy.	✓ 70% for out-of-network.	✓ No coverage for out-of-network	✓ No coverage for out-of-network	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.	✓ Benefit levels change depending on Tier Level of the Drug. No coverage for out-of-network	✓ Benefit levels change depending on Tier Level of the Drug. No coverage for out-of-network	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.				
Speciality Drugs	<b>√</b>	✓ No coverage for out-of-network.	✓ No coverage for out-of-network	✓ No coverage for out-of-network	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.	✓ Benefit levels change depending on Tier Level of the Drug. No coverage for out-of-network	Benefit levels change depending on Tier Level of the Drug. No coverage for out-of-network	Coverage for out-of-network is limited and subject to claim review and may be paid at an In-Network benefit rate.				

ennsylvania Insurance Departr omparison of Essential Health		k Plans for Selection of I	Benchmark Plan for Use in 2	2017	Key: ✓ = covered text in boxes descri		L = limited coverage	= not addressed in f	ederal summary of current EHB-base	e benchmark plan
	Current EHB Base-	Largest Small Group Plans			PA State Employee Health Plans		Federal Employees HBP Benchmark Plans			Largest Largest FEDVIP Largest FEDV CHIP Dental Vision
Benefits*	Benchmark Plan [Aetna HMO (POS)] <sup>1</sup>	1 - Keystone Health Plan East (IBC HMO) <sup>2</sup>	2 - Highmark (PPO) <sup>3</sup>	3 - Geisinger Quality Options (PPO) <sup>4</sup>	4 - PPO <sup>5</sup>	5 - HMO⁵	6 - BCBS Standard Option PPO <sup>6</sup>	7 - BCBS Basic Option PPO <sup>6</sup>	8 - GEHA Standard Option PPO <sup>7</sup>	UPMC for MetLife Federal Dental Plan – High Option <sup>10</sup> Kids  MetLife Federal Dental Plan – High High Option <sup>10</sup>
Rehabilitative & Habilitative Services & 7 Devices										
Outpatient Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Therapy)	✓ combined PT/OT limit 30 visits per year; ST limit 30 visits per year	combined PT/OT limit 30 visits per year; ST limit 30 visits/ per year; cognitive rehabilitative therapy excluded unless integral to other supportive therapies in a program to designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma	combined limit on number of rehab/hab visits per year: 30 OT visits, 30 PT visits, 30 ST visits	✓ combined PT/OT/ST limit : 30 visits per year	ST covered due to a medical diagnosis or for treatment ot autism sectrum disorders. ST not covered for "developmental"; cognitive rehabilitative therapy not covered	✓ subject to combined outpatient therapy visit limit of 60 visits per year; cognitive rehabilitative therapy not covered	✓ combined PT/ST/OT limit of 75 visits per year, plus cognitive rehabilitation therapy	✓             combined PT/ST/OT limit of 50 visits             per year, plus cognitive rehabilitation             therapy	combined hab/rehab PT/OT/ST limit of 60 visits per year . Long-term rehab therapy not covered. Services intended to teach or enhance IADLs not covered.	
Habilitative Services		**PT/OT/ST are subject to shared visit limits with rehabilitative services.  **Plan document defines habilitative services as "Includes treatments designed to enable a Member with a disability to attain, improve, and retain skills and functioning for daily living."  **Not covered: maintenance of chronic conditions and any therapy services provided for ongoing treatment of chronic medical conditions not subject to significant functional improvement  **Not covered: any care that extends beyond traditional medical management for autism, pervaisive developmental disorders, ADD, learning diabilities, behavioural problems, intellectual disability, or treatment or care to effect environmental or social change	**PT/OT/ST are subject to shared visit limits with rehabilitative services.  ** Plan documents cover hab/rehab services that "promote your recovery or the restoration, maintenance or improvement in the level of function following disease, illness or injury, including therapies to achieve functions or skills never acquired due to congenital and developmental anomalies"  **Not covered (not full list of exclusions in plan document): Any care related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change. Excluded services include c) services provided for purposes of behavioral modification and/or training; d) services related to the treatment of learning disorders or learning disabilities; e) services provided primarily for social or environmental change or for respite care; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a reasonable and predictable period of time.	or improve skills for daily living. Such services may include physical and occupational therapy, speech - language pathology, autism spectrum disorder services, and other services as may be determined by a provider and the PPO."  **Any treatment or care related to autistic diseases of childhood, hyperkinetic syndrome, learning disabilities, behavioural problems and mental retardation, which extend beyond traditional medical management are not covered except	**Plan exclusions include::     *Care related to autism spectrum disorders above the annual limit and for Members age 21 and over, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation that extends beyond traditional medical management; *Therapy service which is not primarily provided for its therapeutic value in the treatment of an illness, disease, injury or condition. By way of example but not of limitation, therapy services	spectrum disorders above the annual limit and for Members age 21 and over, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation that extends beyond traditional medical management;  *Therapy service which is not primarily provided for its therapeutic value in the treatment of an illness, disease, injury or condition. By way of	Not specified. Excluded from general PT/OT/ST/cognitive therapy coverage: recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay; maintenance or palliative rehabilitative therapy	Not specified. Excluded from general PT/OT/ST/cognitive therapy coverage: recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay; maintenance or palliative rehabilitative therapy	combined hab/rehab PT/OT/ST limit of 60 visits per year.  **Long-term rehab therapy not covered. **Services intended to teach or enhance IADLs not covered.  **Plan documents define habilitative therapy as " initiated to address a genetic, congenital, or early acquired disorder resulting in significant deficit of ADL, fine motor, or gross motor skills. Therapy services are provided to enhance functional status and is focused on developing skills that were never present. In order to make individual-specific authorizations decisions, OrthoNet will review the treating provider's evaluation; including diagnosis, duration of symptoms, nature or severity of symptoms, anticipated improvement in symptoms, anticipated timeframe for therapy. Evaluations must include standardized age-appropriate tests documenting a condition/ developmental delay resulting in ADL, fine motor or gross motor functionality. Progress in therapy is defined as measurable progress toward achieving realistic functional goals/life skills (Activities of Daily Living) within a predictable period of time toward a member's maximum potential.	
Applied Behavioral Therapy (ABA)		0	0	✓	✓	✓	0	0	0	
Infusion Therapy		✓	✓	✓	✓	✓	✓	✓	✓	
Cardiac Rehab Therapy		✓ 36 visits per year	✓	✓ 36 visits per year	✓ 18 visits per year	subject to combined outpatient therapy visit limit of 60 visits per year	✓	✓	✓	
Respiratory/Pulmonary Rehab Therapy		✓ 36 visits per year	✓	✓ 36 visits per year	√  12 visits per year for pulmonary rehab; no limit on respiratory therapy	subject to combined outpatient therapy visit limit of 60 visits per year	<b>✓</b>	✓	✓	

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	Current EHB Base-				PA State Employee Health Plans		Federal Employees HBP Be		hmark Plans	Largest Largest FEDVIP Largest FEDVIP CHIP Dental Vision			
Benefits*	Benchmark Plan [Aetna HMO (POS)] <sup>1</sup>	1 - Keystone Health Plan East (IBC HMO) <sup>2</sup>	2 - Highmark (PPO) <sup>3</sup>	3 - Geisinger Quality Options (PPO) <sup>4</sup>	4 - PPO <sup>5</sup>	5 - HMO <sup>5</sup>	6 - BCBS Standard Option PPO <sup>6</sup>	7 - BCBS Basic Option PPO <sup>6</sup>	8 - GEHA Standard Option PPO <sup>7</sup>	UPMC for MetLife Federal Dental Plan – High Option High Option			
Durable Medical Equipment	<b>√</b> \$2500 per year	<b>√</b>	✓	not covered: batteries, motor driven equipment,. vommunication devices		follows Medicare guidelines in determining what is covered	√   limit \$1,250 per year on speech-   generating devices; communication   devices otherwise not covered	limit \$1,250 per year on speech- generating devices; communication devices otherwise not covered	computer devices to assist with communication not covered				
Prosthetics		√ wigs not covered	✓	limit one prosthetic device per 5 years, except for members under age 19 and prosthetics following mastectomy.  Wigs are not covered.	follows Medicare guidelines in determining what is covered. Wigs not covered	follows Medicare guidelines in determining what is covered . Wigs not covered	✓ wigs limited at \$350 for one wig per lifetime	√ wigs limited at \$350 for one wig per lifetime	✓ wigs not covered				
Orthotics		foot orthotics only covered as a result of diabetes	foot orthotics only covered as a result of diabetes	<b>✓</b>	✓ follows Medicare guidelines	√   follows Medicare guidelines	shoes, including diabetic shoes, are not covered	shoes, including diabetic shoes, are not covered	<b>✓</b>				
Vision Hardware (Adults)		\$100 reimbursement per year for eyeglasses or contact lenses	0	0	0	0	0	0	0				
Hearing Aids - Adults		⊗			<b>⊗</b>	0		with traumatic injury or malformation					
Cochlear Implants		0	Not specified	Not specified	Not specified	Not specified	✓	✓	✓				
8 Laboratory Services		,	,	,	,	,	,						
Diagnostic Test (X-Ray and Laboratory Tests)	Yes	<b>√</b>	<b>√</b>	<b>√</b>	<b>√</b>	<b>✓</b>	<b>√</b>	<b>√</b>	<b>√</b>				
Imaging (CT/PET Scans, MRIs)	Yes	<b>√</b>	<b>√</b>	✓	✓	✓	✓	✓	<b>√</b>				
Genetic Testing		✓     for a specific disease risk due to family history, or exposure to environmental factors known to cause physical or mental disorders	Not specified	Not specified	Not specified Not covered are genetic counseling and genetic studies that are not required for diagnosis or treatment of genetic abnormalities according to Plan guidelines.	Not specified Not covered are genetic counseling and genetic studies that are not required for diagnosis or treatment of genetic abnormalities according to Plan guidelines.	covered when medically necessary to diagnose and/or manage a patient's existing medical condition	covered when medically necessary to diagnose and/or manage a patient's existing medical condition	Not specified				
Allergy Testing		✓	✓	Not specified	✓	✓	✓	✓	<b>V</b>				
Preventive & Wellness Services & Chronic 9 Disease Management									100 tests per year				
Preventive Care/Screening/Immunization (all plans adhere to standard lists of services and frequencies)	<b>√</b>	✓	✓	✓	✓	✓	✓	✓	✓				
Diabetes Education		✓	✓	✓	✓	✓	✓	✓	√ limit \$250 per year				
Diabetes - Medically Necessary Equipment & Supplies		✓	✓	✓	✓	✓	✓	✓	iiiiii φ≥σσ pei yeai				
Routine Hearing Exam (Adult)		0	$\otimes$	coverage only for treatment related to illness or injury	0	0	L only related to illness or injury, and for prescribing hearing aids	L only related to illness or injury, and for prescribing hearing aids	r coverage only for treatment related to illness or injury				
Sterilization		L only for women; reversals not covered	✓	L only for women; reversals not covered	L not specified if covered for men; reversals not covered	L not specified if covered for men; reversals not covered	✓ reversals not covered	✓ reversals not covered	✓ reversals not covered				
Enteral Formula for Inborn Errors of Metabolism		Covers medical foods for inherited errors of metabolism, covers nutritional formulas when sole source of nutrition for infant/child with Severe Systemic Protein Allergy		√ formula may also be covered if it's the sole source of nurtrion	✓	<b>√</b>	✓	✓	Not specified				

nnsylvania Insurance Depart mparison of Essential Health		k Plans for Selection of	Benchmark Plan for Use in 2	017	Key: ✓ = covered		L = limited coverage	= not addressed in f				
	Current EHB Base-				PA State Emplo	oyee Health Plans		Federal Employees HBP Benchmark Plans			Largest FEDVIP Dental	Vision
Benefits*	Benchmark Plan [Aetna HMO (POS)] <sup>1</sup>	1 - Keystone Health Plan East (IBC HMO) <sup>2</sup>	2 - Highmark (PPO) <sup>3</sup>	3 - Geisinger Quality Options (PPO) <sup>4</sup>	4 - PPO <sup>5</sup>	5 - HMO <sup>5</sup>	6 - BCBS Standard Option PPO <sup>6</sup>	7 - BCBS Basic Option PPO <sup>6</sup>	8 - GEHA Standard Option PPO <sup>7</sup>	UPMC for Kids <sup>8</sup>	MetLife Federal Dental Plan – High Option <sup>9</sup>	
ediatric Services, Including Oral & Vision care												
Dental Check-Up - Child	√ 2 per year	✓ 2 per year	✓ 2 per year	0	⊗		L plan pays nominal amount for a list of services	<b>√</b>	L plan pays 50% of plan allowance for 2 exams and cleanings per year and \$75 in X-rays per year.	2 per year \$1,500 limit per year on all preventive, diagnostic, and other dental services (excluding orthodontia)	√ 2 per year	
Dental Care - Child	0	<b>√</b>	✓ deductible does not apply to pediatric dental care	0	$\otimes$		L plan pays nominal amount for a list of services			\$1,500 limit per year on all preventive, diagnostic, and other dental services (excluding orthodontia)	\$10,000 annual benefit limit	
Orthodontia - Child***	0	L only for abnormalites that severely compromise health. Requires a 1 year waiting period and has a 24 month treatment limit	L only to treat a severe abnormality. Requires a 1 year waiting period. Deductible does not apply.	0	$\otimes$		0		$\otimes$	\$5,200 lifetime limit; covered only when medically necessary	\$3,500 lifetime limit	
Routine Eye Exam - Children	√ 1 per year	✓ 1 per year	✓ 1 per year	✓ 1 per year	$\otimes$	0	Only as a result of accidental injury or surgery; or for treatment of amblyopia and strabismus for children through age 18.	surgery; or for treatment of amblyopia	<b>√</b>	√ 1 per year		√ 1 per ye
Eye Glasses - Child	✓ 1 per year	✓ 1 per year	✓ 1 per year	✓ 1 per 2 years or contact lenses	$\otimes$				$\otimes$	\$100 allowance per year		√ 1 per yea
Hearing Aids - Child				⊗	0		external ear or middle ear (such as a surgically induced malformation or	with traumatic injury or malformation	a pour per ear per o years			
Routine Hearing Exam - Child		0	0	0	0	0			0			
ther leep Studies		✓	Not specified	Not specified	Not specified	Not specified	✓	✓	Not specified			
Christian Science Practitioners/Facilities		Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Not specified	Limit 50 sessions with CS practitioner per year. Limit 30 days nursing care and room and board in a CS facility per year .			

\*Mapping to the 10 ACA benefit categories is approximate.

<sup>\*\*\*</sup> Pursuant to 45 CFR 156.115(d), even though an EHB-benchmark plan may cover the following benefits, an issuer of a plan offering EHB may not include: routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and/or non-medically necessary orthodontia.

<sup>&</sup>lt;sup>1</sup> Aetna Health Maintenance Organization. PA POS Cost Sharing 34 1500 Ded - https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/pennsylvania-ehb-benchmark-plan.pdf

<sup>&</sup>lt;sup>2</sup> Keystone Health Plan East, Inc. Keystone Health Benefits Plan - http://www.portal.state.pa.us/portal/server.pt/document/1496314/2014\_khpc\_pdf <sup>3</sup> Highmark PPO Blue. HHIC Shared Cost PPO \$1500 OFFX - http://www.portal.state.pa.us/portal/server.pt/document/1496312/2014\_hhic\_pd

<sup>&</sup>lt;sup>4</sup> Geisinger Quality Options, Inc. Geisinger Choice Marketplace Direct Group - http://www.portal.state.pa.us/portal/server.pt/document/1496531/Geisinger%20summary.pdf

<sup>&</sup>lt;sup>5</sup> Pennsylvania EmployeesBenefit Trust Fund. Summary Plan Description - https://www.pebtf.org/PDF/SPD.pdf

<sup>&</sup>lt;sup>6</sup> FEHBP Blue Cross and Blue Shield Service Benefit Plan - http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/71-005.pdf

<sup>&</sup>lt;sup>7</sup> FEHBP Government Employees Health Association, Inc. Benefit Plan - http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/71-006.pdf

<sup>&</sup>lt;sup>8</sup> Pennsylvania's Children's Health Insurance Program. UPMC Health Plan UPMC for Kids.

<sup>&</sup>lt;sup>9</sup> FEDVIP The MetLife Federal Dental Plan - http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/MetLife.pdf

<sup>&</sup>lt;sup>10</sup> FEDVIP Blue Cross Blue Shield FEPBlueVision - http://cvw1.davisvision.com/forms/StaticFiles/English/FEP2014BenefitBooklet.pdf